Northern Ontario Families of Children with Cancer

NOFCC Financial Assistance Program

(Please Print Clearly & Fill out form completely)

Child's Name: _____ Birth Date: ____/____/____
First Last Month Day Year

Status: ☐ Active Treatment ☐ Active Follow Up (start date): ____/____/_____
(period of receiving treatment) (1 year following end of active treatment)

Primary Family Contact: _____ Phone #: _____
First Name Last Name

Reimbursement to be sent by email transfer to: _____ (for money transfer)

PLEASE ONLY SEND ONE FORM PER MONTH

Date(s)	# of Days	$20/day Local App't	$30/day Out of Town App't	Pediatric Oncology Center	Pediatric Oncology Center Hospital Signature
Totals:				Total Payment _____	

Parent Signature: _____ Date: _____

For NOFCC use only:

Cheque or EFT #: _____ Issue Date: _____ NOFCC Authorization: _____

** Local= within 100km from home **Out of town= beyond 100km from home

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